bitten; limbs quiet. Fit lasted half-an-hour, after which he felt tired and sleepy. These fits came on every second day about 11 a.m., and were preceded by a feeling of "wishing to be alone." The fits continued for three months, and at the end of this time patient entered a hospital in Dublin, where the surgeons decided to trephine; but patient objected to this, and he was given small doses of calomel for two hundred consecutive hours. The result of this treatment was severe ptyalism and complete cessation of the fits. Has had no recurrence since. Nine months later had occasional attacks of cholerine for two months whilst in Marseilles. In December, 1885, began to complain of an easy, painless, non paroxysmal cough, generally worse in the morning, attended with a small amount of greyish-colored and tenacious sputa. In the intervals of coughing, patient sp at up bright red, frothy blood, varying in quantity from a teaspoonful to three tablespoonfuls, and, he says, as much as 20 ounces upon one occasion. Had night sweats; no diarrhœa; lost flesh somewhat. Remained in a hospital in Paris for two months, where, under the use of the hot hammer and blisters to the chest, he improved very much, and returned to England. Three months later, through having "caught cold," patient had a return of the above symptoms in about the same degree of severity. He now entered the Brompton Hospital, where, under treatment (cod-liver oil, porter, and nourishing diet), he improved so much that at the end of five weeks he left the hospital able to resume his usual occupation. Shortly after there was a return of all his previous symptoms in a slighter degree, and he entered the Victoria Park Hospital. Here, under a similar course of treatment, he improved much in health and strength, and continued to do so until 26th September, 1886, when after just arriving in Montreal was seized with, he says, a severe attack of diarrhœa, stools being watery, yellow, and streaked with blood, the passage of each stool being attended with a good deal of pain and tenesmus; complained also of abdominal cramps and vomiting. the ejecta consisting of food taken. Had a slight attack of spitting of blood. No cough nor thoracic pain. These symptoms were preceded by chills and feverishness. Upon admission, these were the symptoms complained of by patient; but, upon examination, the stools passed were quite normal in appearance, and he had no attack of vomiting.

Examination—Of average height; weight 118 lbs.; sparely, though well-built; anæmic; dark complexioned; skin warm and moist; muscles not wasted; no evidence of injury to head; no evidences of syphilis; nails not incurvated; tongue pale and moist, coated in centre with slight white fur-edges indented. Pulse 84, regular, and of good volume. Respiration 18, regular. Temperature 99°. Physical examination of the heart and lungs is negative. Examination of the larynx by Dr. Major reveals nothing abnormal. Dr. Johnston's report upon the sputum (?) is as follows: "A dark-brown fluid, odor aromatic, contains traces of food, considerable number of fat globules, and numerous, epithelial scales, also a few mold filaments; not examined for bacilli, as none of the usual elements of sputum were found; no blood-cells to be seen in specimen." Urine 52 ozs., very pale color; no deposit; 1022; no sugar, no albumen.

During patient's stay in the hospital his chest was frequently examined, with negative results; the spurious expectoration was subjected to rigid examinations, with the same result as that at first arrived at. He was closely watched for these attacks of spitting of blood, but never could he be caught in the act. The symptoms complained of disappeared upon admission; his appetite was good, the bowels regular, slept well, gained in weight, and nothing unusual developed until 30th October, when, at 2 p.m., he was seized with violent and excessive pain in the umbilical region, and upon examination, even the slightest touch caused excruciating pain and made him cry out. The position assumed was as follows: Recumbent posture; left arm held closely to the body and forearm flexed to a right angle; fingers of left hand strongly abducted from the median line and semi-flexed; the left thumb was firmly adducted and flexed to a right angle. The fingers and thumb were easily straightened, but soon flew back to their original state. The act of moving the fingers apparently pained him very much. The right upper extremity was not at all affected. The lower extremities were markedly rigid and extended. Feet extended and all the toes pointed forwards, except the left great one, which was bent backwards and almost touched the dorsum of the foot. Unexpected tickling or pinching the lower extremities would cause the existing rigidity to pass off, and the legs would suddenly be drawn up. When attention is drawn to it, no amount of tickling or pricking with a pin would cause any starting of the extremities or give evidence of pain. Patient